APPLICATION FOR PARTICIPATION IN
AFTER SCHOOL CARE SNACK COMPONENT (AREA ELIGIBLE)
TENNESSEE CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

1. NAME AND ADDRESS OF AGENCY (Also include county): TELEPHONE NUMBER: AC ( )	2. NAME AND TITLE OF CACFP REPRESENTATIVE (Identify staff member who is responsible for record-keeping functions and can be contacted for programmatic information):

3. NAME, ADDRESS AND DATE OF BIRTH OF DIRECTOR AND BOARD CHAIRPERSON:

Name of Director:	Home Address of Director:	Date of Birth of Director:
Name of Board Chairperson:	Home Address of Board Chairperson:	Date of Birth of Board Chairperson:

4. TYPE OF AGENCY (Check only one): ____ PUBLIC ____ PRIVATE NON-PROFIT (Attach a copy of IRS letter which documents federal income tax exemption) ____ Church (Attach a copy of letter from Tennessee Department of Revenue which documents state sales tax exemption) ____ Proprietary, For Profit (Attach copy of most recent DHS-EAV, **OR** copies of Child Care Certificates for at least 25% of enrollment)	5. DOES YOUR AGENCY NOW PARTICIPATE OR HAVE YOU PARTICIPATED IN PROGRAM(S) FUNDED THROUGH THE USDA IN THE PAST THREE YEARS? ____ Yes ____ No (If "Yes", provide name of program(s) and dates of participation)

6. DOES YOUR AGENCY PARTICIPATE IN THE CACFP IN ANY OTHER STATE(S):

____ Yes (If yes, list the state(s): _____

_____

____ No

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7. RECEIPT OF FEDERAL FUNDS:

Did the total federal funds received by the agency through the State of Tennessee and expended during the agency's prior fiscal year, **and** the total federal funds received by the agency directly from the federal government and expended during the agency's prior fiscal year exceed $500,000: ____ Yes ____ No **(Do not include any vendor child care payments received under the Tennessee Child Care Certificate Program in this determination.)**

If the total federal funds exceeded $500,000, the agency is required to have an audit of the funds to participate in the CACFP.

8. HOW MANY FEEDING SITES WILL PARTICIPATE IN THE SNACK PROGRAM: _____

Are all site(s) under the direct administration of your agency:

___ Yes ___ No

9. DOES AGENCY RECEIVE TITLE III MEAL FUNDING OR COMMODITIES?

___ Yes

___ No

10. COMPLETE **EXHIBIT A** for <u>each</u> feeding site and **EXHIBIT B** for <u>all</u> feeding sites.

11. COMPLETE ATTACHED BUDGET IN **EXHIBIT C** (The budget will be reviewed to determine if adequate personnel are available to administer the program. For any positions that will perform CACFP responsibilities and that are not included in the budget, please attach information that provides the names of the employees, position titles, duties and funding sources.)

12. **POTENTIAL ELIGIBLE BENEFICIARIES BY ETHNIC/RACIAL CATEGORIES:**

Provide the number of potential eligible children in your service area by the **ethnic** categories below:

Hispanic or Latino: _____ Not Hispanic or Latino: _____

Provide the number of potential eligible children in your service area by the **racial** categories below:

American Indian or Alaskan Native: _____ Asian: _____ Black or African American: _____

Native Hawaiian or Other Pacific Islander: _____ White: _____

13. IF YOU PROPOSE TO OPERATE MORE THAN ONE FOOD SERVICE SITE, PROVIDE A SCHEDULE FOR CONDUCTING MONITORING REVIEWS OF EACH FOOD SERVICE SITE. (Each food service site must be visited and monitored for program compliance purposes at least three times each program year, including one review during the first six weeks of operation.)

14. TRAINING FOR EACH EMPLOYEE PERFORMING CACFP DUTIES MUST BE PROVIDED AT LEAST ONCE FOR THE PROGRAM YEAR BEGINNING OCTOBER 1 AND ENDING SEPTEMBER 30. IDENTIFY YOUR AGENCY'S ANTICIPATED DATE(S) FOR IN-HOUSE TRAINING FOR THE PROGRAM YEAR.

Month	Day	Year

15. IF YOU PROPOSE TO OPERATE MORE THAN ONE FOOD SERVICE SITE, DESCRIBE YOUR PROCEDURES FOR CONDUCTING PRE-APPROVAL VISITS TO PROPOSED FOOD SITES TO EVALUATE CAPACITY TO OPERATE FOOD SERVICES.

16. DOES AGENCY HAVE A GOVERNING BOARD: ___ YES ___ NO. IF YES, LIST THE NAMES AND ADDRESSES OF ALL CURRENT MEMBERS BELOW. YOU MAY ATTACH A SEPARATE LIST.

NAME:	ADDRESS:

17. IF A GOVERNING BOARD DOES NOT EXIST, IDENTIFY THE NAME AND ADDRESS OF YOUR AGENCY'S ADMINISTRATOR/CHIEF EXECUTIVE OFFICER:

NAME:	ADDRESS:

18. ARE ALL FOOD SERVICE SITES IDENTIFIED IN THIS APPLICATION AN INTEGRAL PART OF YOUR AGENCY: ___ YES ___ NO. TO BE AN INTEGRAL PART OF YOUR AGENCY, A FOOD SERVICE SITE MUST BE UNDER THE SUPERVISION AND DIRECT CONTROL OF YOUR AGENCY'S GOVERNING BOARD OR CHIEF ADMINISTRATIVE OFFICER.

19. IF APPLYING TO PARTIIPATE IN THE CACFP FOR THE FIRST TIME, PLEASE INCLUDE AS **EXHIBIT D** THE MENU(S) TO BE UTILIZED IN THE SNACK PROGRAM FOR EACH FOOD SERVICE SITE.

20. EACH AGENCY APPROVED FOR CACFP PARTICIPATION MUST DISTRIBUTE NEWS RELEASES ANNOUNCING ITS PARTICIPATION IN THE CACFP. PLEASE IDENTIFY BELOW THE NAMES OF THE LOCAL NEWS MEDIA, MINORITY OR OTHER GRASSROOTS ORGANIZATIONS TO RECEIVE THESE NEWS RELEASES. THE NEWS RELEASES ARE TO BE DISTRIBUTED AFTER APPROVAL FOR CACFP PARTICIPATION IS RECEIVED FROM THE TENNESSEE DEPARTMENT OF HUMAN SERVICES. YOUR AGENCY IS **NOT** REQUIRED TO HAVE THE NEWS RELEASES PUBLISHED IN NEWSPAPERS AS A LEGAL NOTICE. A SAMPLE NEWS RELEASE IS CONTAINED IN **EXHIBIT E**.

IDENTIFY LOCAL NEWS MEDIA, MINORITY AND GRASSROOTS ORGANIZATIONS TO RECEIVE NEWS RELEASES:

1.	2.
3.	4.
5.	6.
7.	8.

21. IDENTIFY BELOW THE PERSONNEL IN YOUR AGENCY WHO ARE AUTHORIZED TO SIGN CLAIMS FOR CACFP REIMBURSEMENT:

_____ Name and Title

_____ Name and Title

_____ Name and Title

_____ Name and Title

22. IDENTIFY THE NAME AND ADDRESS OF ANY BOOKKEEPING OR CPA FIRM USED TO PERFORM ACCOUNTING FUNCTIONS FOR THE CACFP:

23. FINANCIAL VIABILITY (FOR NON-GOVERNMENTAL SPONSORING AGENCY ONLY):

Please include one of the following documents with your application:

A. A copy of a "Letter of Credit" from your banking institution that identifies available credit that is equal to (or greater than) the Reimbursement received by your agency for an average two-month period during the last twelve months; or

B. A copy of the letter entitled "Independent Auditor's Report" that is contained in an audit report for your center that is not more than two years old; or

C. A copy of your center's most recent checking accounting statement; or

D. A copy of a financial statement for your center's last business year which is signed and dated by an authorized representative and which identifies the following:

(1) Assets (cash, securities, real estate, etc.),

(2) Liabilities (notes payable, mortgages, other liabilities, etc.),

(3) Total annual expenditures for all programs and activities of the agency, and

(4) Total annual income from all sources received by the agency.

24. MANAGEMENT CONTROLS FOR PROGRAM ACCOUNTABILITY (FOR NON-GOVERNMENT SPONSORING AGENCY ONLY):

Please complete, sign and date the attached Sample Form to Document Required Management Controls contained in **EXHIBIT F** and return it with your application.

25. CIVIL RIGHTS COMPLIANCE: Answer each question for your agency's Civil Rights Compliance:

Does your agency provide meal services regardless of race, color, national origin, sex, age, or disability? ____ Yes ____ No

Is membership in any organization a prerequisite for the meal services? ____ Yes ____ No If yes, what is organization's name?

_____

Does your agency have procedures for handling complaints? ____ Yes ____ No

Has your agency received any discrimination complaint(s)? ____ Yes ____ No

If discrimination complaint(s) have been received, attach information describing what action has been taken.

CERTIFICATION STATEMENT

I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND THAT I WILL ACCEPT FINAL ADMINISTRATIVE AND FINANCIAL RESPONSIBILITY FOR THE TOTAL AFTER SCHOOL CARE SNACK PROGRAM AT THE FEEDING SITE(S) IDENTIFIED HEREIN. I ALSO CERTIFY THAT REIMBURSEMENT WILL BE CLAIMED ONLY FOR THOSE SNACKS SERVED TO ELIGIBLE PARTICIPANTS AND THAT THE MEAL SERVICE WILL BE AVAILABLE TO ALL ELIGIBLE PARTICIPANTS REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, SEX, HANDICAP, OR AGE.

I ALSO CERTIFY THAT THE AGENCY HAS PARTICIPATED IN THE FOLLOWING PUBLICLY FUNDED PROGRAMS DURING THE PAST SEVEN YEARS AND THAT NEITHER THE AGENCY NOR ANY OF ITS PRINCIPALS ARE INELIGIBLE TO PARTICIPATE IN THESE PROGRAMS BY REASON OF VIOLATION OF THE REQUIREMENTS OF THESE PROGRAMS DURING THAT PERIOD:

LIST OF PUBLICLY FUNDED PROGRAMS: _____

_____

_____

I FURTHER CERTIFY THAT NEITHER THE AGENCY OR ANY OF ITS PRINCIPALS HAVE BEEN CONVICTED OF ANY ACTIVITY THAT OCCURRED DURING THE PAST SEVEN YEARS AND THAT INDICATED A LACK OF BUSINESS INTEGRITY. CONVICTIONS INDICATING A LACK OF BUSINESS INTEGRITY INCLUDE FRAUD, ANTITRUST VIOLATIONS, EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, RECEIVING STOLEN PROPERTY, MAKING FALSE CLAIMS, AND OBSTRUCTION OF JUSTICE.

I UNDERSTAND THAT THIS INFORMATION IS BEING GIVEN IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS, AND THAT A DELIBERATE MISREPRESENTATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE STATE AND FEDERAL CRIMINAL STATUES. I ALSO UNDERSTAND THAT ANY AGENCY AND INDIVIDUALS PROVIDING FALSE CERTIFICATIONS WILL BE PLACED ON THE USDA NATIONAL DISQUALIFIED LIST AND WILL BE SUBJECT TO ANY OTHER APPLICABLE CIVIL OR CRIMINAL PENALTIES.

NAME AND TITLE OF AGENCY BOARD CHAIRPERSON OR AUTHORIZED AGENCY REPRESENTATIVE:

_____ _____

Name Title

SIGNATURE OF AGENCY BOARD CHAIRPERSON OR AUTHORIZED AGENCY REPRESENTATIVE:

_____ _____

Signature Date

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EXHIBIT A

FEEDING SITE INFORMATION

SITE NUMBER: _____

1. LOCATION OF FEEDING SITE (Also include county):

_____

Street City State

County: _____

2. NAME AND ADDRESS OF SCHOOL(S) THAT SERVE THE AREA IN WHICH FEEDING SITE IS LOCATED:

School (must have one or more of the grades of kindergarten through sixth grade):

_____

Name Street City State

School (must have one or more of the grades of kindergarten through sixth grade):

_____

Name Street City State

School (must have one or more of the grades of kindergarten through sixth grade):

_____

Name Street City State

3. DOES FEEDING SITE HAVE CHILD CARE LICENSE : ___ YES ___ NO IF YES, ATTACH COPY OF LICENSE. IF NO, HAS FEEDING SITE BEEN INSPECTED FOR FIRE AND FOOD SERVICE SAFETY: ___ YES ___ NO. IF YES, ATTACH COPIES OF FIRE AND/OR FOOD SERVICE INSPECTION REPORTS.

4. DAYS OF THE WEEK IN OPERATION: _____ THROUGH _____

5. HOURS OF OPERATION: FROM: _____ TO: _____

6. NUMBER OF OPERATING DAYS PER WEEK:

7. NUMBER OF OPERATING WEEKS PER YEAR:

8. ANNUAL DATES OF OPERATION:

STARTING: _____

ENDING: _____

9. LIST ANY MONTHS DURING WHICH THE AFTER SCHOOL SNACK PROGRAM WILL NOT OPERATE:

_____

SITE NUMBER: _____

10. TIME MEAL SERVICE BEGINS:	11. TIME MEAL SERVICE ENDS:	12. NO. OF MEALS TO BE SERVED PER DAY:

13. METHOD BY WHICH MEALS WILL BE PROVIDED: ____ Preparation at meal service location ____ Preparation at central kitchen ____ Under contract with local school system ____ Under contract with food service management company (Attach copy of food service contract)

14. AGE RANGE OF PARTICIPANTS: FROM: _____ TO: _____	15. NUMBER OF ANTICIPATED DAILY PARTICIPANTS: _____

16. DESCRIBE THE EDUCATION AND/OR ENRICHMENT ACTIVITIES TO BE PROVIDED IN THE AFTER SCHOOL PROGRAM:

EXHIBIT D

IF APPLYING FOR THE CACFP FOR THE FIRST TIME, INSERT MENU(S) TO BE UTILIZED BY FOOD SERVICE SITE(S)

EXHIBIT E

PUBLIC RELEASE FOR
AFTER SCHOOL CARE SNACK COMPONENT (AREA ELIGIBLE)
CHILD AND ADULT CARE FOOD PROGRAM

_____ announces the sponsorship of
(NAME OF AGENCY)

the after school care snacks under the Child and Adult Care Food Program. Snacks will be provided at no separate charge to eligible children served at the following site(s):

NAME:	ADDRESS:

All snacks will be provided in accordance with the U.S. Department of Agriculture non-discrimination policy which prohibits discrimination based on race, color, national origin, gender, age, disability, and political beliefs. (Not all prohibited bases apply to all programs.)

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EXHIBIT C

BUDGET FOR CACFP OPERATIONS OF AFTER SCHOOL CARE SNACK PROGRAM FOR AT-RISK CHILDREN

Required Financial Documents:

If your snack program will budget and charge any labor costs to the CACFP, the following financial documents must be used:

1. Your program will be required to have a Written Compensation Policy which identifies the following for all employees who are charged to the CACFP: rates of pay; hours of work, including breaks and meal periods; policy and payment schedule for regular compensation, overtime, compensatory time, holiday pay, benefits, severance pay and payroll withholding.

2. Your program will be required to use a Time and Attendance Report to identify the total time actually worked by each full or part-time employee who is charged to the CACFP. **You will find attached a sample Time and Attendance Report which you may use in your CACFP. If you choose to use another form, the form must collect, as a minimum, the same information collected by the sample form.** Time and Attendance Reports must be prepared timely and coincide with employee pay periods. The reports must identify starting time, ending time, and absences for each day of work.

3. Your program will be required to have Time Distribution Reports to establish and support the salaries or wages to be charged as CACFP labor costs. **You will find attached a sample Time Distribution Report which you may use in your CACFP. If you choose to use another form, the form must collect, as a minimum, the same information collected by the sample form.**

Definitions:

1. Operating Costs: Costs related to the preparation and serving of meals under the CACFP.

2. Administrative Costs: Costs related to the planning, organizing, and managing of the CACFP food service, including the preparation and submission of the CACFP funding application; the review and approval of income eligibility applications for participants; the provision of nutrition education and other program training for employees; the performance of monitoring reviews of sponsored facilities; and the preparation and submission of claims for reimbursement.

Allowance for Indirect Administrative Costs:

If indirect costs are budgeted, you must attach a photocopy of letter from a federal agency or the Tennessee Department of Human Services which approves an indirect cost rate or cost allocation plan for your program.

CACFP FOOD SERVICE BUDGET FOR AFTER SCHOOL CARE SNACK PROGRAM FOR AT-RISK CHILDREN

Name of Program: | **Estimated CACFP Payments for Program Year: $**

EXPENSES BY OBJECT	PROPOSED OPERATING COSTS	APPROVED COSTS (TO BE COMPLETED BY DHS ONLY)	PROPOSED ADMINISTRATIVE COSTS	APPROVED COSTS (TO BE COMPLETED BY DHS ONLY)	TOTAL APPROVED COSTS (TO BE COMPLETED BY DHS ONLY)
Salaries/wages to prepare/ serve meals (excluding benefits/payroll taxes)	$	$			$
Fringe benefits/payroll taxes for employees who prepare/serve meals	$	$			$
Food Costs (must be at least 50% of estimated CACFP payments for program year)	$	$			$
Expendable Supplies (i.e., napkins, straws, dishwashing detergent, etc.)	$	$			$
Durable Supplies (i.e., items costing less than $5,000 with life expectancy of more than 1 year)	$	$			$
Contracted meal services (enter amount if meals to be purchased from private company)	$	$			$
Contract personnel (non-employees who are under contract to prepare/serve meals)	$	$			$
Food service equipment purchase **(must attach description of each equipment item)**	$	$			$
Food service equipment rental and maintenance	$	$			$
Salaries/wages for CACFP administrative employees (excluding benefits/payroll taxes)			$	$	$
Fringe benefits/payroll taxes for CACFP administrative employees			$	$	$
Office Supplies			$	$	$
Communications			$	$	$
Postage, Printing and Publications			$	$	$
Contract personnel (non-employees who perform administrative duties)			$	$	$
Occupancy			$	$	$
Travel (If any projected costs, complete Page 4 of the budget)			$	$	$
TOTAL OPERATING AND ADMINISTRATIVE COSTS	$	**$**	$	$	$

PERSONNEL SALARY SCHEDULE FOR AFTER SCHOOL CARE SNACK PROGRAM FOR AT-RISK CHILDREN

OPERATING PERSONNEL				
Employee Name	**Position Title**	**Duties**	**Annual Salary or Wages (including Fringe Benefits and Taxes)**	**Amount of Employee Salary or Wages to be Charged to CACFP**
			$	$

ADMINISTRATIVE PERSONNEL				
Employee Name	**Position Title**	**Duties**	**Annual Salary or Wages (including Fringe Benefits and Taxes)**	**Amount of Employee Salary or Wages to be Charged to CACFP**
			$	$

PROPOSED TRAVEL BUDGET

1. TRAVEL (In-State)	**Name of Employee/Contract Individual:** _____ **Reason for Travel:**_____ **Estimated Cost: $**_____
2. TRAVEL (In-State)	**Name of Employee/Contract Individual:** _____ **Reason for Travel:**_____ **Estimated Cost: $**_____
3. TRAVEL (In-State)	**Name of Employee/Contract Individual:** _____ **Reason for Travel:**_____ **Estimated Cost: $**_____
4. TRAVEL (In-State)	**Name of Employee/Contract Individual:** _____ **Reason for Travel:**_____ **Estimated Cost: $**_____
5. TRAVEL (Out-of-State)	**Name of Employee/Contract Individual:** _____ **Reason for Travel:**_____ **Estimated Cost: $**_____

EXHIBIT F

SAMPLE FORM TO DOCUMENT REQUIRED MANAGEMENT CONTROLS FOR SPONSOR OF AFTER SCHOOL CARE SNACK PROGRAM FOR AT-RISK CHILDREN

As mandated by the federal regulation at 7 CFR Part 226.6 (b) (18), each new or renewing sponsoring agency must have a financial system with written management controls. To document the management controls utilized by your agency, please provide the following information:

1. What is the frequency for depositing all cash receipts (including checks) at your banking institution:

   _____

2. Who is authorized to perform the following:

   a. Deposit all cash receipts (including checks) at your banking institution:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   b. Open the mail:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   c. Review the CACFP budget (approved by the Tennessee Department of Human Services) before incurring costs that are charged to the program:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

   d. Review vendor invoices for correctness of the quantities received and prices charged before payment is made:

      Name: _____ Position Title: _____

      Name: _____ Position Title: _____

e. Ensure that pre-numbered checks are utilized for the payment of all costs:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

f. Record all checks when issued:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

g. Safeguard all unused checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

h. Retaining all voided checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

i. Ensure that no checks are issued payable to cash:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

j. Mail checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

k. Receive statements and cancelled checks from your banking institution:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

l. Reconcile monthly bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

m. Review reconciled bank statements:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

n. Review monthly statements for outstanding balances owed:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

o. Approve, sign, and distribute payroll checks:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

p. Prepare monthly CACFP claims for reimbursement:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

q. Contact the Tennessee Department of Human Services on all CACFP claims that are <u>not</u> paid within 30 days of submission;

Name: _____ Position Title: _____

Name: _____ Position Title: _____

3. Who is responsible for ensuring that all labor costs charged to the CACFP are supported by Time and Attendance Records which identify the starting time, ending time, and absences for each working day in each pay period:

Name: _____ Position Title: _____

Name: _____ Position Title: _____

4. Who is responsible for ensuring that Time Distribution Records are maintained for all employees who perform both CACFP operational and administrative duties, or duties for the CACFP and other programs.

   Name: _____ Position Title: _____
   Name: _____ Position Title: _____

5. Who is responsible for ensuring that payroll records are maintained for each employee charged to the CACFP:

   Name: _____ Position Title: _____

   Name: _____ Position Title: _____

   The payroll records must include the following information:

   a. Employee name;

   b. Rate of pay;

   c. Hours worked;

   d. Benefits earned;

   e. Any reductions or increases to the employee's base compensation, such as overtime pay;

   f. Gross pay;

   g. Net pay;

   h. Date of payment;

   j. Method of payment, such as check or electronic funds transfer; and

   k. Verification that employee has been paid, such as canceled checks or electronic funds transfer deposit verification.

6. Describe the procedures for employees to request and receive approval for annual and sick leave;

   _____

   _____

   _____

7. Who has access to the personnel files of employees:

   Name: _____ Position Title: _____

   Name: _____ Position Title: _____

8. Who is responsible for maintaining an inventory of all equipment purchased with CACFP funds:

   Name: _____ Position Title: _____

   Name: _____ Position Title: _____

   The CACFP defines equipment as an item of non-expendable personal property with a useful life of more than 1 year and an acquisition cost of $5,000 or more per unit.

NAME AND TITLE OF AUTHORIZED INSTITUTION OFFICIAL:

_____ _____

NAME TITLE

SIGNATURE OF AUTHORIZED INSTITUTION OFFICIAL:

_____ _____

SIGNATURE DATE